



Commonwealth of Massachusetts
MassHealth Drug Utilization Review Program
P.O. Box 2586
Worcester, MA 01613-2586

Fax: 1-877-208-7428 **Phone:** 1-800-745-7318

Growth Hormone Adult Prior Authorization Request

MassHealth reviews requests for prior authorization (PA) on the basis of medical necessity only. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including current member eligibility, other insurance, and program restrictions. MassHealth will notify the provider and member of its decision. Keep a copy of this form for your records. If faxing this form, please use black ink.

Prior authorization is required for all growth hormone products. Information about which drugs require PA can be found within the MassHealth Drug List at **www.mass.gov/masshealth**.

Member information

Last name	First name	MI	MassHealth member ID no.	Date of birth	Sex (Circle one.) f m
Member's place of residence <input type="checkbox"/> home <input type="checkbox"/> nursing facility					

Medication information

Drug name requested	Dose, frequency, and duration		Drug NDC (if known) or service code	
Indication for GH: For HIV wasting, fill out Section A. For growth hormone deficiency (GHD) syndrome in adults, fill out Section B.				
Section A				
HIV wasting - Initial prior authorization				
Current height	Current weight		Date	
Premorbid weight	Date	Diagnosis		
CD4 count	Date	Has member intentionally lost weight?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Describe attempted nutritional supplementation _____ _____ _____				
Has member attempted therapy with dronabinol (Marinol) or megestrol acetate (Megace)? If so, provide dates and duration. If not, please explain why. _____ _____ _____				
Describe current antiretroviral therapy. _____ _____				
Any known tumors? <input type="checkbox"/> Yes <input type="checkbox"/> No		Is this a female patient who is pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No		
HIV wasting - Reauthorization				
Current height	Current weight		Date	
Has member maintained or gained weight with GH treatment? _____				

Medication information (cont.)

Section B

Growth hormone deficiency (GHD) syndrome in adults

Current height	Current weight	Date
Is the growth hormone deficiency adult onset? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If so, provide etiology of GH deficiency. _____ _____		
Please provide dates and results of GH stimulation tests performed. If stimulation test was not performed, please explain why not. _____ _____		
IGF-I level	Date	
Provide detailed signs and symptoms of growth hormone deficiency syndrome and provide documentation of diagnostic procedures, lab tests, radiological tests, and clinical findings. _____ _____		
Any known tumors? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is this a female patient who is pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Provide date of last appointment with endocrinologist		

Pharmacy information

Name	Pharmacy provider no.	Telephone no. ()	Fax no. ()
Address	City	State	Zip

Prescriber information

Last name	First name	MI	MassHealth provider no.	DEA no.
Address	City	State	Zip	
E-mail address	Telephone no. ()	Fax no. ()		

Signature

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Prescriber's signature (Stamp not accepted.)

Date